JOINING FORCES Joining Families

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REAL WORLD RESEARCH FOR FAMILY ADVOCACY PROGRAMS

FEATURED INTERVIEW

Conceptualization and Measurement of Child Neglect

Interview with Howard Dubowitz, MD. by James E. McCarroll, PhD

Howard Dubowitz, MD

Howard Dubowitz, MD, is Professor of Pediatrics and the Director of the Center for Families at the University of Maryland Medical School in Baltimore, Maryland. He received his medical training at the University of Cape Town, South Africa, completed an internship in Israel, a pediatric residency at Boston City Hospital, and a fellowship in child abuse and neglect at Children's Hospital, Boston. Dr. Dubowitz, who holds a Master of Science degree in epidemiology from the Harvard School of Public Health, is widely published and renowned for his clinical work, teaching, research, and advocacy. Among his numerous professional honors, he is the recipient of the American Academy of Pediatrics' Special Achievement Award. Dr. Dubowitz is one of the principal investigators of the LONGitudinal Studies of Child Abuse and Neglect (LONGSCAN), a 20 year study in its 17th year of data collection (see Runyan et al., 1998, for a description of the Longscan Study)[1]. A bibliography of studies from the LONGSCAN is available at http://www.iprc.unc.edu.

Dr. McCarroll: Based on your international experiences, training, and practice, what do we know about child maltreatment across cultures?

Dr. Dubowitz: To the best of my knowledge all cultures have a taboo against child sexual abuse, although cross-cultural differences do exist. For example, a majority of countries do not have prohibitions against child pornography. Physical abuse issues are a little trickier. Even within the state of Maryland there are differences. For example, some people may equate

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1. Runyan DK, Curtis PA, Hunter WM, Black MM, Kotch JB, Bangdiwala S, Dubowitz H, English D, Everson MD, & Lansdverk J. (1998). LONGSCAN: A consortium for longitudinal studies of maltreatment and the life course of children. *Aggression and Violent Behavior*, 3:275–285.

In This Issue

The Spring *Joining Forces Joining Families* (JFJF) newsletter focuses on child neglect, an issue of importance for the United States Army as well as for our nation. In the Army, rates of child neglect have risen since 2001. Our featured interview is with child neglect expert, Howard Dubowitz, MD, Professor of Pediatrics at the University of Maryland Medical School. We review his recent research on child neglect prevention and intervention and comment on the implications of his work for reducing child neglect in the Army. *Building Bridges* explores statistical concepts related to the measurement of child neglect and describes two types of scales developed for research, clinical, and administrative purposes. *Websites of Interest* offers some links to resources on child neglect including an excellent manual, *Child Neglect: Guide for Prevention, Assessment and Intervention,* published by the Children's Bureau, U.S. Department of Health and Human Services. As always, we welcome your feedback on how JFJF has been or can be helpful in your outreach to our community that continues to experience extreme stress and uncertainty.

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any hitting of a young child as abuse while others accept spanking as appropriate in some circumstances.

Four major risk factors for child abuse and neglect are depression, substance abuse, domestic violence, and parental stress.

Dr. McCarroll: Tell us a little about your Center.

Dr. Dubowitz: Our Center is within the Department of Pediatrics at the University of Maryland Medical School. We have four main activities: clinical programs, clinical research, teaching, and advocacy. Our goal is to encourage the development of policies that will help children and families within the city, the state, and nationally.

Dr. McCarroll: In your teaching and research do you address the intersection of child and adult maltreatment?

Dr. Dubowitz: I generally do raise it as an issue. I think this is an important intersection. One of the projects that we are completing is focused on routine screening for domestic violence by pediatricians.. There are studies showing that parents, usually mothers, will report domestic violence to pediatric and other medical staff when asked.

Dr. McCarroll: What is the best way to screen for child or adult maltreatment?

Dr. Dubowitz: I recommend using a screening instrument. Screening cannot and must not be limited to visual examination. So much gets missed when you depend only on gross examination, such as the woman with the black eye. Abuse is a problem that is often well masked.

Dr. McCarroll: Would you say the same thing about child abuse? Would you rely on a screening instrument as opposed to a visual examination or verbal report?

Dr. Dubowitz: I think the difficult question is what instrument to use. If there were something practical it would be quite attractive. However, this has been elusive. As part of a project called SEEC – a safe environment for every child –we included two questions that seem to be important. They were part of a one-page questionnaire that parents completed while waiting for the child's appointment. (1) "Have you been concerned that your child may have been sexually abused?" and (2) "Have you felt the need to hit your child?" These questions have shown some predictive value. The big problem is that of response bias in the direction of social desirability and how does one circumvent it. [*Editor's note: Social desirability is presenting oneself in an overly favorable light.*] In a current study that we are conducting with about 85–90 pediatricians in private practice, we are targeting risk factors such as depression, substance abuse, domestic violence and parental stress as the four big contributors to child abuse and neglect.

Dr. McCarroll: Your earlier papers emphasize the ecological model as developed by Brofenbrenner (1979) and Belsky (1980). Do you still teach this as a way of conceptualizing how children are affected by their world?
[Editor's note: The ecological model is a theory emphasizing the multiple interacting factors that contribute to child abuse and neglect.]

Dr. Dubowitz: Yes, it is a major focus. It is important for professionals, when these cases evoke feelings of pain, anger, and dismay, to recognize that neglectful parents are not simply evil people. Where these models can be helpful is to caution us not to excuse the behavior, but to understand that there are underpinnings to some of these problems. I often will suggest that pediatricians think of abuse and neglect

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JOINING FORCES
Joining Families

Editor-in-chief
James E. McCarroll, Ph.D.
Email: jmccarroll@usuhs.mil

Editor
John H. Newby, MSW, Ph.D.
Email: jnewby@usuhs.mil

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Editorial Advisor
LTC Mary Dooley-Bernard, MSW
Family Advocacy Program Manager
Headquarters, Department of the Army
E-mail: Mary.Dooley-Bernard@cfsc.army.mil

Editorial Consultants
David M. Benedek, M.D., LTC, MC, USA
Associate Professor and Scientist
Center for the Study of Traumatic Stress
Uniformed Services University of the Health Sciences
dbenedek@usuhs.mil

Nancy T. Vineburgh, M.A.
Director, Office of Public Education and Preparedness
Center for the Study of Traumatic Stress
Email: nvineburgh@usuhs.mil

A Review of Recent Research of Howard Dubowitz, MD

James E. McCarroll, Ph.D. and Robert J. Ursano, M.D.

Three basic needs of children are for emotional support and affection, protection from family conflict, and from community violence.

Much of Dr. Dubowitz's work has focused on child neglect, a complex social problem. Child neglect accounts for the largest number of cases and highest rates of any kind of maltreatment in the U.S. civilian society and in the Army. Recent data also indicate that child neglect in the U.S. Army has risen during recent deployments.

Child neglect has been difficult to define, both in research and in practice. Some communities have more concern for physical aspects of child care while others may focus more on psychological issues. However, there is overall general agreement on the circumstances that are harmful to children (Dubowitz, Klockner Starr, & Black, 1998). Part of the discussion of child neglect is whether to categorize subtypes and, if so, how. In a study of the relationships of three major subtypes of neglect (physical, psychological, and environmental), Dubowitz, Pitts, and Black (2004) found modest correlations among the neglect subtypes indicating some degree of overlap, while still suggesting somewhat unique factors in each.

A recent conceptual model of child neglect at ages 4–6 (Dubowitz et al., 2005) identified 12 children's needs, and conceptualized neglect as occurring when these basic needs are not adequately met. This study related child needs to longitudinal measures of child maltreatment. Three basic needs were derived: emotional support/affection, protection from family conflict, and protection from community violence. The model then assessed whether these three constructs were related to children's adjustment at age 8. Low perceived support from the mother was associated with child behavior problems. Exposure to family conflict and children's sense of experiencing little early affection were associated with both child behavior problems and with social problems. The investigators concluded that conceptualizing neglect as the failure to meet children's needs could help build our understanding of child neglect.

An important part of Dr. Dubowitz's work is educating health care professionals on family maltreatment. Two articles on child neglect provide very clear and useful language and approaches for providers of health care. The first (Dubowitz, Giardino & Gustavson, 2000) describes manifestations of child neglect, provides principles for assessment and management of neglect and suggests that caregivers focus on children's basic needs rather than on the omissions of parenting. The second article (Dubowitz, 2002) describes the importance of preventing child abuse and neglect, identifies risk and protective factors for child maltreatment, and provides guidance on screening, brief assessment, and initial management of child maltreatment.

Programs emphasizing parenting efficacy could play a valuable role in enhancing the involvement and parenting skills of fathers.

One of the important issues that Dr. Dubowitz has emphasized in his research and teaching is the association between father involvement and child neglect. In a 2000 study, Dubowitz and colleagues found that the mere presence of a father did not significantly influence the degree of neglect of the child, but the nature of his involvement did. Fathers who felt more effective as parents were less likely to neglect their children. Less neglect was associated with fathers' longer duration of involvement, more involvement with household tasks, and less involvement in child care (Dubowitz, Black, Kerr, Starr, & Harrington, 2000). The investigators thought that the sense of parenting efficacy might represent parenting skills and suggested that caregivers could play a valuable role in enhancing the involvement and parenting skills of fathers.

In a very recent article, Dr. Dubowitz (Dubowitz, 2006) commented on two studies on child neglect (Coohey, 2006; Pittman & Buckley, 2006), reviewed the significant research on fathers and child maltreatment, and described the current need to understand the roles of fathers in child rearing and child maltreatment. Coohey found several predictors of recidivism among fathers who abused their children: (1) father unemployed, (2) not the biological father of all the children in

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Review of Dubowitz Research, *from page 3*

the family, (3) denying responsibility for his behavior, (4) having previously maltreated a younger child, and (5) seriously injured a child. Dubowitz noted that an important clinical implication of Coohey's work was getting fathers to acknowledge their own responsibility, which has implications for both prevention and intervention.

Dubowitz suggests that caregivers focus on children's basic needs rather than on omissions of parenting.

Dubowitz noted that Pittman and Buckley's study of 2,841 offenders treated in the U.S. Air Force Family Advocacy Program found many similarities and few differences between mothers and fathers of neglected children. The mothers reported more distress and more problems outside the family, while fathers reported more rigid expectations of children and less family cohesion. Taking into account such differences may help tailor treatment interventions to address specific problems that differ for mothers and fathers.

Finally, Dr. Dubowitz has performed community research on the effectiveness of strategies to prevent child neglect. The program, Family Connections, was a demonstration project of a prevention strategy assessed in 154 families who received the intervention for 3 months or 9 months (DePanfilis & Dubowitz, 2005). The outcomes of the program were protective factors (parenting attitudes, parenting sense of competence, family functioning, and social support), key risk factors for neglect (caregiver depressive symptoms, parenting stress, and everyday stress), child safety (physical and psychological care of the child), and child behavior (caregiver reports of child internalizing and externalizing behavior). Internalizing behavior included somatic complaints and withdrawn, anxious, or depressive behavior. Externalizing behavior was measured as delinquency or aggressiveness. The intervention aimed to improve protective factors, diminish risk factors, and thereby improve child safety and behavior. Interestingly, the 9 month program had few advantages over the 3 month program. This finding reinforces the need for research on the optimal length of intervention for community-based programs.

There are many implications of Dr. Dubowitz's work for the Army Family Advocacy Program as well as suggestions for further research. Among the research and program development opportunities within the Army community are to: (1) determine the types and prevalence of subtypes of neglect; (2) clarify the degree of overlap of neglect subtypes with other types of neglect and with other types of child maltreatment, and domestic violence; (3) develop neglect prevention programs targeting the subtypes of neglect and the highest risk families; and (4) understand the meaning and implications of children's experiences of neglect and risk for harm.

Dr. Dubowitz's work in the field of child neglect can help educate and inform the Army community. In the current context of rapid, long, and repeated military deployments, it is often hard for parents to balance all the needs of the active duty member(s) and the children. Further understanding of child neglect in our own community can protect our nation's children and strengthen the Army family.

Research possibilities involving neglect:

- prevalence of subtypes
- targeting neglect prevention programs for the most prevalent subtypes
- degree of overlap of subtypes and other forms of child maltreatment
- child neglect and domestic violence
- the meaning of children's experiences of neglect and the risk of harm

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Building Bridges to Research: Defining and Measuring Child Neglect

James E. McCarroll, Ph.D. and Robert J. Ursano, M.D.

Reliability refers to the consistency of a measurement.

Defining and measuring child neglect is challenging. Sound empirically based assessments are needed. This article provides some examples of neglect definitions and measures that have been developed for research and clinical use. The examples illustrate the types of measures used. Increased knowledge of measures of neglect can aid the Army Family Advocacy Program in its mission.

Straus and Kantor (2005) suggest a definition of neglect, provide a conceptual analysis of that definition, and identify principles, criteria and problems in creating measures of neglect. Their definition highlights the *neglectful behaviors of a caregiver* that constitute failures to meet the developmental needs of a child. Thus, neglect is conceptualized as failure to meet needs in contrast to inflicting harm. Its causes and motives are also different.

Kantor and Straus, at the Family Research Laboratory at the University of New Hampshire, have developed a number of measures of child neglect. One of these is the Multidimensional Neglectful Behavior Scale-Child Report (MNBS-CR) (Kantor et al., 2004). It measures four primary domains of neglectful behavior: emotional, cognitive, supervision and physical neglect. Good psychometric properties were demonstrated in their validation samples.

The term *psychometric properties* refers to measures that have been obtained in the development of an instrument. Generally, at a minimum, these include measures of reliability and validity. Reliability and validity are two basic concepts in test development and measurement. There are many types of both reliability and validity. In general, reliability refers to the consistency of a measurement. Test-retest reliability is the degree of agreement achieved when a measure is given on two different occasions. For example, if intelligence is measured on two separate occasions under the same circumstances, the results should be very similar. Inter-rater reliability is a measure of the degree of agreement of two or more persons rating the same event. An example of inter-rater reliability is the degree of agreement between persons judging candidates for a job. Validity, on the other hand, is a different concept. There are several types of validity. In general, validity indicates the degree to which you are measuring the concept or behavior that you are attempting to measure. Concurrent validity is the degree of agreement of a new measure, say a test, with one that has already been validated. Predictive validity is a measure of how well a test predicts some criterion. For example, in maltreatment research, we would like to have a measure with high predictive validity for recidivism. That is, it would accurately and with high probability predict recidivism risk. High predictive validity is generally required for clinical use.

Validity indicates the degree to which you are measuring the concept or behavior that you are attempting to measure

Internal consistency reliability is another psychometric measurement property. In developing their measures, Kantor et al. (2004) included a clinical sample of 144 children, ages 6–15 and a comparison sample of 87 children. The full version of the MNBS-CR had high internal consistency reliability among both the younger (alpha=.66) and older children (alpha=.94) with neglect concerns. Alpha is a measure of the internal consistency of a scale. Internal consistency measures the extent to which scale items correlate with each other. The higher the value of alpha, the more the items measure the same idea and the higher is the internal consistency. Scores above 0.60 indicate reasonable internal reliability. For more information on scales and measures, see http://www2.chass.ncsu.edu/garson/PA765/standard.htm.

Correlations among the MNBS-CR subscales ranged from moderate to high indicating overlap between the subscales. Correlational analyses between the total neglect scores and child outcomes provide some support for construct validity of the MNBS-CR. In addition, analyses of the relationship between MNBS-CR reports and caretaker reports were conducted to address construct and predictive validity. (The MNBS-CR scales should be used only with permission of Straus and Kantor. Contact the

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***Building Bridges to Research**, from page 5*

authors at: http://www.unh.edu/frl/unpubpap.htm.)

Another instrument that focuses upon the measurement of child neglect is the Child Neglect Index (CNI) (Trocme, 1996). It was designed as a substantiation tool for child welfare practitioners and researchers to easily measure the type and severity of child neglect. Trocme's definition of neglect is based on criteria used by child welfare workers and, accordingly, reflects a more legal than clinical approach. In contrast to Straus and Kantor's conceptualization of neglect, the CNI defines neglect in terms of the different forms of physical or emotional harm that is seen in neglected children.

Concurrent validity is the degree of agreement of a new measure with one that has already been validated.

The CNI is a single page instrument including the following six scales: supervision, nutrition, clothing and hygiene, physical health care, mental health care and developmental/educational care. For all scales an inadequate or neglect rating requires evidence of impairment or harm or exposure to situations that could cause harm.

The CNI was field tested in a large welfare agency on 127 consecutive intake investigations. Two scales, psychological care and developmental care, were correlated above .50. Test-retest reliability was assessed by the completion of the CNI by the intake workers twice within two weeks. Test-retest reliability scores for each scale were acceptable, with a range from .83 (developmental/educational care) to .91 (supervision). Interrater reliability scores on individual scales ranged from .69 to .95 with a mean of .79. Validity and reliability of the CNI compare favorably to longer and more detailed measures of child neglect.

Straus and Kantor (2005) give additional helpful information on the conceptualization and measurement of neglect in a recent article. They discuss neglect definitions, principles and criteria for the measurement of neglect separately from harm, various measures of neglectful behavior and their psychometric properties, and implications for research and practice. Although there are differences in the measurement of child neglect, there continues to be an ongoing need for interventions and supportive services for neglected children and neglectful parents. Enhancing our knowledge and understanding of measurement characteristics associated with the study of child neglect should significantly contribute to this important task.

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Trocme N. (1996). Development and preliminary evaluation of the Ontario Child Neglect Index. *Child Maltreatment, 1*:145–155.

***Review of Dubowitz Research**, from page 4*

Three major subtypes of child neglect are physical, psychological, and environmental.

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Dubowitz H, Pitts SC, & Black MM. (2004). Measurement of three major subtypes of child neglect. *Child Maltreatment, 9*:344–356.

Pittman JF & Buckley RR (2006). Comparing maltreating fathers and mothers in terms of personal distress, interpersonal functioning and perceptions of family climate. *Child Abuse & Neglect, 30*:481–496.

***Dr. Dubowitz Interview**, from page 2*

as symptoms. That seems to help take some of the edge off of angry feelings and helps us realize the importance of the family, cultural, and community issues that contribute to the situation.

Parents, most of the time, would like for life to be good for their children. The big question is to understand what gets in the way of good intentions.

Dr. McCarroll: It sounds like this approach could be helpful to parents as well as to physicians.

Dr. Dubowitz: I am always careful when presenting the model to not let parents off the hook. It is walking a bit of a tightrope. I do say that parents have the primary responsibility to protect and nurture their children. The cliché that it takes a village is, however, actually kind of true.

Dr. McCarroll: The high rates of neglect in the U.S. civilian community and the Army are of concern. In many publications one reads about subtypes of neglect, but most jurisdictions do not publish data on subtypes. What is the value of categorizing neglect into subtypes? Would this help to target interventions?

Dr. Dubowitz: Again, there is quite a bit of variation across states. Very often, states have two, three or four subtypes. One of them is often called *failure to provide*. This includes the physical aspects of childcare such as food and housing, clothing, and, sometimes, health care. The second main subtype that is often used is *lapses in supervision*. Some also have *educational neglect*, but generally it is the physical aspects of children exposed to hazards and concerns about supervision that states are most concerned about.

Dr. McCarroll: Do you think the subtypes are primarily for researchers? Are clinicians interested in using such categorization?

Dr. Dubowitz: I think that this is not a question just for researchers. These different subtypes are, in fact, different. To lump together, for example, the child who has inadequate nutrition with a child who is abandoned does not make much sense. The circumstances are quite different. One could argue that for the individual clinician, even having subtypes is too crude. I say this as a clinician. For example, the criminal law on abandonment in one state requires that about 15 or 20 different contextual variables need to be taken into account. In the instance of a child left alone, contextual variables might be the age of the child, the time of day, how long is the child left alone, are the utilities functioning in the house, is there food in the house, does the child know how to reach a parent? In cases of failure to thrive, contextual variables also make a huge difference. Clinicians, even sometimes without even using the terminology, recognize this variability and try to probe the specific circumstances. By doing so they are paying attention to the differences across and even within subtypes.

From an administrative standpoint, I can see how, for example, child protective services might lump these different categories into failure to provide. For researchers as well there is a need to clarify the meaning of these different experiences for children. Also, there is substantial overlap between the subtypes.

In the LONGSCAN, for example, with 1,300–1,400 children, in a subsample of children who have experienced lapses in supervision, it gets pretty tricky because many of these children have experienced other types of neglect or other forms of maltreatment as well. [*Editor's note: See the Dr. Dubowitz's biography for a reference that describes the LONGSCAN.*]

But I should also give another perspective. There are differences and subtypes of neglect, but ultimately these are symptoms of parents having difficulty meeting their children's basic needs. From a conceptual standpoint does it really matter? If one looks at the underlying parental, family, and community dynamics that are underpinning these manifestations, are they likely to be so different? Therein lies a conceptual argument for lumping rather than dividing. So, I think the answer is that it depends specifically on the question. If it is a matter of broader public policy then some of these differences might seem unnecessarily nuanced. On the other hand, if it's trying to understand the specifics around the feeding of young children then the issue of that specific subtype might be quite important.

Dr. McCarroll: You mentioned in one of your articles that various risk factors such as substance abuse, depression, non-biological parents, and others, have low predictive value for neglect.

Dr. Dubowitz: I hope I have not been dismissive of risk factors because we need a variety of strategies. Even if a particular risk factor has a low predictive value, I think when you start combining them the predictive power gets bet-

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ter. This gets back to definitional issues. Both domestic violence and maternal depression are strong risk factors for child abuse. If one is looking at only parental age, then the connection is weaker.

Dr. McCarroll: What are the underpinnings of risk factors? Is this the question of what lies behind the parents' failure to adequately take into account their children's needs?

Dr. Dubowitz: For a long time it has been convenient to point and wag a finger at a guilty parent, but I think one might take a broader epidemiological view, a public health perspective saying, "Wait a moment." You know, if we are in a society that says on the one hand says we love children and at the same time one in four girls and maybe one in ten boys are sexually abused, I think it behooves us to take this broader perspective of what are the contributors that are underpinning these facts.

I have stubbornly held on to the view that most parents most of the time would like for things to be good for their children. So the big question as we try and put a dent in this problem is to better understand what gets in the way of, hopefully, good intentions.

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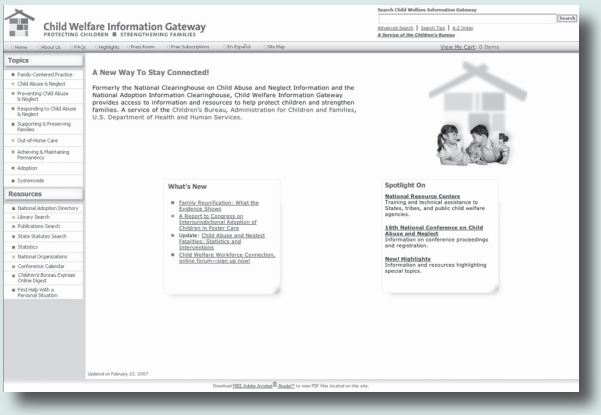
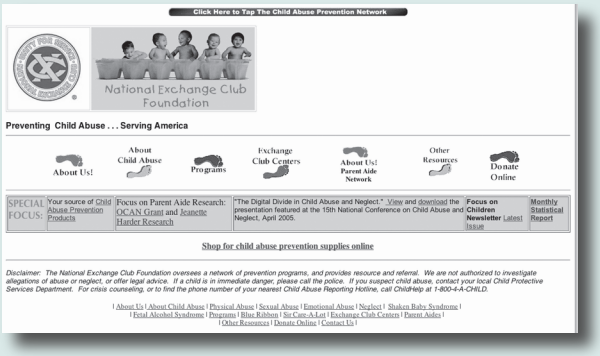
Websites of Interest on Child Neglect





The National Child Information Gateway **http://www.childwelfare.gov** is composed of the National Clearinghouse on Child Abuse and Neglect and the National Adoption Information Clearinghouse. This site includes many valuable resource links including state statues on child abuse and neglect search, publications search, and a section on topics of interest in child abuse and neglect.

A recent (2006) manual entitled Child Neglect: Guide for Prevention, Assessment and Intervention is available from **http://www.childwelfare.gov** online. This publication is a comprehensive document published by the Children's Bureau, U.S. Department of Health and Human Services, and authored by Diana DePanfilis, University of Maryland School of Social Work, Baltimore, MD. This manual provides extensive information on neglect that can be used for educational or academic purposes as well as prevention, assessment, and intervention. This is a valuable document that should be in every Family Advocacy Program and Social Work Service library.

There are many websites offered by privately funded groups and individuals. For example, the National Exchange Club Foundation, Toledo, Ohio, focuses on preventing child maltreatment **http://www.preventchildabuse.com**. They work directly with parents through parent aides and have a nationwide network of nearly 100 centers to provide support for families at-risk. Their page on neglect presents definitions of four subtypes (physical, educational, emotional, and medical neglect) and has additional information on fetal alcohol syndrome and shaken baby syndrome, and a list of their resource centers.